IN-HOME SUPPORTIVE SERVICES PROGRAM
NOTICE OF PROVIDER INELIGIBILITY

COUNTY OF

(ADDRESSEE)

Notice Date: _____

Provider Name: _____

IHSS Office Address: _____

IHSS Office Telephone Number: _____

To: In-Home Supportive Services (IHSS) Provider Applicant

The county has found that you are not eligible to be enrolled as an IHSS provider or to receive payment from the IHSS program for providing services. You are not eligible because you did not complete one or more of the required steps of the IHSS provider enrollment process. You did not complete the step(s) marked below:

- ☐ You did not complete, sign or return the IHSS Provider Enrollment Form (SOC 426).
- ☐ You did not attend an IHSS Provider Orientation session.
- ☐ You did not sign the IHSS Provider Enrollment Agreement (SOC 846).
- ☐ You did not submit fingerprints and go through a criminal background check.

If you have any questions about this letter, call _____ .